95TH CONGRESS
1ST SESSION

H. R. 7079

IN THE HOUSE OF REPRESENTATIVES

MAY 10, 1977

Mr. ROGERS introduced the following bill; which was referred jointly to the Committees on Ways and Means and Interstate and Foreign Commerce

A BILL

To provide for the reform of the administrative and reimbursement procedures currently employed under the medicare and medicaid programs, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Medicare-Medicaid Administrative and Reimbursement Reform Act".

TABLE OF CONTENTS

CRITERIA FOR DETERMINING REASONABLE COST OF HOSPITAL SERVICES

SEC. 2. (a) (1) The first sentence of section 1861 (v) (1) (A) of the Social Security Act is amended by striking out "The" and inserting "Subject to subsection (aa), the".

(2) Section 1861 (v) of the Act is also amended by adding at the end the following paragraph:

"(8) For additional requirements applicable to determination of reasonable cost for services provided by hospitals, see subsection (aa).".

(b) Section 1861 of the Act is amended by adding after subsection (z) the following subsection:

"CRITERIA FOR DETERMINING REASONABLE COST OF HOSPITAL SERVICES

"(aa) (1) To more fairly and effectively determine reasonable costs incurred in providing hospital services, the Secretary shall, not later than April 1, 1978, after consulting with appropriate national organizations, establish—

"(A) an accounting and uniform functional cost reporting system (including uniform procedures for allocation of costs) for determining operating and capital costs of hospitals providing services, and

"(B) a system of hospital classification under which hospitals furnishing services will initially be classified as follows:

"(i) by size, with each of the following groups of hospitals being classified in separate categories: (I) those having more than 5, but fewer than 25, beds, (II) those having more than 24, but fewer than 50, beds, (III) those having more than 49, but fewer than 100, beds, (IV) those having more than 99, but fewer than 200, beds, (V)

those having more than 199, but fewer than 300, beds, (VI) those having more than 299, but fewer than 400, beds, (VII) those having more than 399, but fewer than 500, beds, and (VIII) those having more than 499 beds,

"(ii) by type of hospital, with (I) short-term general hospitals being in a separate category, (II) hospitals which are the primary affiliates of accredited medical schools (with one hospital to be nominated by each accredited medical school) being in one separate category (without regard to bed size), and (III) psychiatric, geriatric, maternity, pediatric, or other specialty hospitals being in the same or separate categories, as the Secretary may determine appropriate, in light of any differences in specialty which significantly affect the routine costs of the different types of hospitals, and

"(iii) other criteria which the Secretary may find appropriate, including modification of bed-size categories;

but the system of hospital classification shall not differentiate between hospitals on the basis of ownership.

"(2) The term 'routine operating costs' used in this subsection does not include:

"(A) capital and related costs,

"(B) direct personnel and supply costs of hospital education and training programs,

"(C) costs of interns, residents, and non-administrative physicians,

"(D) energy costs associated with heating and cooling the hospital plant, and

"(E) malpractice insurance expense, or,

"(F) ancillary service costs.

"(3) (A) During the calendar quarter beginning on January 1 of each year, beginning with 1979, the Secretary shall determine, for the hospitals in each category of the system established under paragraph (1) (B), an average per diem routine operating cost amount which shall (except as otherwise provided in this subsection) be used in determining payments to hospitals.

"(B) The determination shall be based upon the amount of the hospitals' routine operating costs for the preceding fiscal year.

"(C) In making a determination, the routine operating costs of each hospital shall be divided into personnel and nonpersonnel components.

"(D) (i) The personnel and nonpersonnel components of routine operating costs for each of the hospitals (other than for those excluded under clause (ii)) in each category shall be added for all hospitals and then divided

by the total number of days of routine care provided by the hospitals in the category to determine the average per diem routine operating cost for each category.

"(ii) In making the calculations required by clause (i), the Secretary shall exclude any hospital which has significant understaffing problems or which otherwise experiences significant cost differentials resulting from failure of the hospital to fully meet the standards and conditions of participation as a provider of services as determined by the Secretary.

"(E) There shall be determined for each hospital in each category a per diem payment rate for routine operating costs. That payment rate shall equal the average per diem routine operating cost amount for the category in which the hospital is expected to be classified during the subsequent fiscal year, except that the personnel component shall be adjusted using a wage index based upon general wage levels (including fringe benefit costs) in the areas in which the hospitals are located. If the Secretary finds that, in an area where one or more hospitals in any category are located, for the fiscal year ending June 30, 1977, the wage level (including fringe benefit costs) for hospitals is significantly higher than the general wage level (including fringe benefit costs) in that area (relative to the relationship between hospital wages and general wages in other areas), then

the general wage level in the area shall be deemed equal to the wage level for hospitals in that area, but only during fiscal year 1979.

"(4) (A) (i) The term 'adjusted per diem payment rate for routine operating costs', means the per diem payment rate for routine operating costs plus the average percentage increase in prices determined under succeeding provisions of this subparagraph.

"(ii) In making payments for services, the Secretary shall add a semiannual average percentage increase in the cost of the mix of goods and services (including personnel and nonpersonnel costs) comprising routine operating costs, equal to the lesser of: (I) the average percentage increase estimated by the hospital, or (II) the average percentage increase in the area estimated by the Secretary.

"(iii) At the end of the fiscal year, the amounts paid under clause (ii) shall be adjusted to reflect the lesser of (I) the actual cost increase experienced by the hospital or (II) the actual increase in costs which occurred in the mix of goods and services in the area. Adjustments shall also be made to take account of unexpected changes in the hospital's classification.

"(B) For purposes of payment the amount of routine operating cost incurred by a hospital shall be deemed to equal—

"(i) for a hospital which has actual routine operating costs equal to or greater than that hospital's adjusted per diem payment rate for routine operating costs, an amount equal to the greater of:

"(I) The hospital's actual routine operating costs, but not exceeding 120 percent of the hospital's adjusted per diem payment rate for routine operating costs, or

"(II) the amounts determined for the hospital under clause (I) if it had been classified in the bed-size category nearest to the category in which the hospital was classified, but not exceeding the hospital's actual routine operating costs; and

"(ii) for a hospital which has actual routine operating costs less than that hospital's adjusted per diem payment rate for routine operating costs, an amount equal to (I) the amount of the hospital's actual routine operating costs, plus (II) whichever is smaller: (a) 5 percent of the hospital's adjusted per diem payment rate for routine operating costs, or (b) 50 percent of the amount by which the hospital's adjusted per diem payment rate for routine operating costs exceeds the hospital's actual routine operating costs.

"(C) Any hospital excluded by the Secretary under paragraph (3) (D) (ii), shall be reimbursed for routine

operating costs the lesser of (i) actual costs or (ii) the reimbursement determined under this subsection.

"(D) April 1 of the year in which the Secretary determines the amount of the average per diem operating cost for each hospital category and the adjusted per diem payment rate for each hospital, the determinations shall be published by the Secretary; and the Secretary shall notify the hospital administrator and the administrative governing body of each hospital with respect to all aspects of the determination which affect the hospital.

"(E) If a hospital is determined by the Secretary to be—

"(i) located in an underserved area where hospital services are not otherwise available,

"(ii) certified as being currently necessary by an appropriate planning agency, and

"(iii) underutilized,

the adjusted per diem payment rate shall not apply to that portion of the hospital's routine operating costs attributable to the underutilized capacity.

"(F) If a hospital satisfactorily demonstrates to the Secretary that, in the aggregate, its patients require a substantially greater intensity of care than is generally provided by the other hospitals in the same category, resulting in

unusually greater routine operating costs, then the adjusted per diem payment rate shall not apply to that portion of the hospital's routine operating costs attributable to the greater intensity of care required.

"(G) The Secretary may further increase the adjusted per diem payment rate to reflect the higher prices prevailing in Alaska or Hawaii.

"(H) Where the Secretary finds that a hospital has manipulated its patient mix, or patient flow, or provides less than the normal range and extent of patient service, or where an unusually large proportion of routine nursing service is provided by private-duty nurses, the routine operating costs of that hospital shall be deemed equal to whichever is less: the amount determined without regard to this subsection, or the amount determined under subparagraph (B).

"(5) Where any provisions of this subsection are inconsistent with section 1861(v), this subsection supersedes section 1861(v)."

(c) (1) The Secretary shall, at the earliest practical date, develop additional methods for reimbursing hospitals for all other costs, and for reimbursing all other entities which are reimbursed on the basis of reasonable cost. Those methods shall provide appropriate classification and reimbursement systems designed to ordinarily permit comparisons of the cost centers of one entity, either individually or in

the aggregate, with cost centers similar in terms of size and scale of operation, prevailing wage levels, nature, extent, and appropriate volume of the services furnished, and other factors which have a substantial impact on hospital costs. The Secretary shall provide procedures for appropriate exceptions.

(2) The systems of reimbursement shall not permit payment for costs which exceed 120 percent of the average cost incurred by other institutions or agencies in the same class, unless an exception has been allowed.

(3) The Secretary shall, as classification and reimbursement systems methods are developed, but not later than two years from enactment, submit appropriate legislative recommendations to the Congress.

(d) The provisions of section 1861 (aa) (2), (3), and (4) of the Social Security Act—

(1) shall apply for informational purposes for services furnished by a hospital before October 1, 1979, and

(2) shall be effective for fiscal years beginning with fiscal year 1981.

(e) Notwithstanding any other provision of this Act, where the Secretary has entered into a contract with a State, as authorized under section 222 of Public Law 92–603 or section 1533 (d) of the Public Health Service Act, to estab-

lish a reimbursement system for hospitals, hospital reimbursement in that State under titles XVIII and XIX shall be based on that State system, if the Secretary finds that—

(1) the State has mandated the reimbursement system and it applies to all hospitals in the State which have provider agreements under title XVIII or title XIX;

(2) the system applies to all revenue sources for hospital services in the State;

(3) all hospitals in the State with which there is a provider agreement conform to the accounting and uniform reporting requirements of section 1861(aa)(1)(A), and furnishes any appropriate reports that the Secretary may require; and,

(4)(A) based upon an annual evaluation of the system, aggregate payments to hospitals in the State under title XVIII and title XIX for those components of hospitals costs determined under section 1861(aa) for the fiscal year following an annual evaluation are estimated to be less than payments would be under section 1861(aa) or, (B) where a State that is unable to satisfy requirements of subparagraph (A) demonstrates to the satisfaction of the Secretary that total reimbursable inpatient hospital costs in the

State are lower than would otherwise be payable under title XVIII and title XIX.

If the Secretary finds that any of the above conditions in a State which previously met them have not been met for a year the Secretary shall, after due notice, reimburse hospitals in that State according to the provisions of this Act unless he finds that unusual, justifiable and non-recurring circumstances led to the failure to comply.

(f) (1) Section 1866(a)(1) of the Social Security Act is amended by inserting ", and" in place of the period at the end of subparagraph (C), and by adding a subparagraph: "(D) not to increase amounts due from any individual, organization, or agency in order to offset reductions made under section 1861(aa) in the amount paid, or expected to be paid, under title XVIII.".

(2) Section 1902(a)(27) of the Social Security Act is amended by deleting "and" at the end of subparagraph (A), by inserting ", and" in place of the semicolon at the end of subparagraph (B) and by adding a new subparagraph:

"(C) not to increase amounts due from any individual organization, or agency in order to offset reductions made under section 1902(a)(13)(D) in the amount paid, or expected to be paid under title XIX;"

(h) Section 1902 (a) (13) (D) is amended to read as follows:

"(D) for payment of the reasonable cost of inpatient hospital services provided under the plan, applying the methods specified in section 1861 (v) and section 1861 (aa), which are consistent with section 1122; and".

PAYMENTS TO PROMOTE CLOSING AND CONVERSION OF UNDERUTILIZED FACILITIES

SEC. 3. (a) Part A of title XI of the Social Security Act is amended by adding at the end the following new section:

"PAYMENTS TO PROMOTE CLOSING AND CONVERSION OF UNDERUTILIZED FACILITIES

"SEC. 1132. (a) (1) (A) Before the end of the third full month following the month in which this section is enacted, the Secretary shall establish a Hospital Transitional Allowance Board (referred to in this section as the 'Board'). The Board shall have five members, appointed by the Secretary without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, who are knowledgeable about hospital planning and hospital operations.

"(B) Members of the Board shall be appointed for three-year terms, except some initial members shall be ap-

pointed for shorter terms to permit staggered terms of office.

"(C) Members shall be entitled to per diem compensation at rates fixed by the Secretary, but not more than the current per diem equivalent at the time the service involved is rendered for grade GS–18 in section 5332 of title 5, United States Code.

"(D) The Secretary shall provide technical, secretarial, clerical, and other assistance as the Board may need.

"(2) The Board shall receive, and act upon applications by hospitals certified for participation (other than as 'emergency hospitals') under titles XVIII and XIX for transitional allowances.

"(b) For purposes of this section—

"(1) The term 'transitional allowance' means an amount which—

"(A) shall, solely by reason of this section, be included in a hospital's reasonable cost for purposes of calculating payments under the programs authorized by titles V, XVIII, and XIX, of this Act; and

"(B) in accordance with this section, it is established by the Secretary for a hospital in recognition of a reimbursement detriment (as defined in paragraph (3)) experienced because of a qualified facility conversion (as defined in paragraph (2)).

"(2) The term 'qualified facility conversion' means

closing, modifying, or charging usage of underutilized hospital facilities which is expected to benefit the programs authorized under title XVIII and title XIX by (i) eliminating excess bed capacity, (ii) discontinuing an underutilized service for which there are adequate alternative sources, or (iii) substituting for the underutilized service some other service which is needed in the area and which is consistent with the findings of an appropriate health planning agency.

"(3) A hospital which has carried out a qualified conversion and which continues in operation will be regarded as having experienced a 'reimbursement detriment' (A) to the extent that, solely because of the conversion there is a reduction in the aggregate reimbursement (but only to the extent the capital was accepted as reasonable for purposes of reimbursement) which is considered in determining for payment purposes under title XVIII or title XIX to the hospital the reasonable cost (as the term is used for purposes of those titles) incurred by the hospital; (B) if the conversion results, on an interim basis, in increased operating costs to the extent that operating costs exceed amounts ordinarily reimbursable under titles XVIII and XIX, or (C) in the case of complete closure of a nonprofit, nongovernmental (except local governmental) hospital, other than for replacement of the hospital to the extent of actual debt obligations previously recognized as reasonable for reim-

bursement, where the debt remains outstanding, less any salvage value.

"(c) (1) Any hospital may file an application with the Board (in a form and including data and information as the Board, with the approval of the Secretary, may require) for a transitional allowance with respect to any qualified conversion which was formally initiated after December 31, 1977. The Board, with the approval of the Secretary, may also establish procedures, consistent with this section, by means of which a finding of a reimbursement detriment may be made prior to the actual conversion.

"(2) The Board shall consider any application filed by a hospital, and if the Board finds that—

"(A) the facility conversion is a qualified facility conversion, and

"(B) the hospital is experiencing a reimbursement detriment because it carried out the qualified facility conversion,

the Board shall transmit to the Secretary its recommendation that the Secretary establish, a transitional allowance for the hospital in amounts reasonably related to prior or prospective use of the facility under titles XVIII and XIX, and for a period, not to exceed twenty years, specified by the Board; and, if the Board finds that the criteria in clauses (A) and (B) are not met, it shall advise the Secretary not to estab-

lish a transitional allowance for that hospital. For an approved closure under subsection (b) (3) (C) the Board may recommend or the Secretary may approve a lump-sum payment in lieu of periodic allowances, where such payment would constitute a more efficient and economic alternative.

"(3) (A) The Board shall notify a hospital of its findings and recommendations.

"(B) A hospital dissatisfied with a recommendation may obtain an informal or formal hearing at the discretion of the Secretary, by filing (in the form and within a time period established by the Secretary) a request for a hearing.

"(4) (A) Within thirty days after receiving a recommendation from the Board respecting a transitional allowance or, if later, within thirty days after a hearing the Secretary shall make a final determination whether, and if so in what amount and for what period of time, a transitional allowance will be granted to a hospital. A final determination of the Secretary shall not be subject to judicial review.

"(B) The Secretary shall notify a hospital and any other appropriate parties of the determination.

"(C) Any transitional allowance shall take effect on a date prescribed by the Secretary, but not earlier than the date of completion of the qualified facility conversion. A transitional allowance shall be included as an allowable cost item

in determining the reasonable cost incurred by the hospital in providing services for which payment is authorized under this title": *Provided, however,* That the transitional allowance shall not be considered in applying limits to costs recognized as reasonable pursuant to the third sentence of section 1861 (v) (1) and section 1861 (aa) of this Act or in determining the amount to be paid to a provider pursuant to section 1814 (b), section 1833 (a) (2), section 1910 (i) (3), and section 506 (f) (3) of this Act.".

"(d) In determining the reasonable cost incurred by a hospital with respect to which payment is authorized under a State plan approved under title V or title XIX, any transitional allowance shall be included as an allowable cost item.

"(e) (1) The Secretary shall not, prior to January 1, 1981, establish a transitional allowance for more than a total of fifty hospitals.

"(2) On or before January 1, 1980, the Secretary shall report to the Congress evaluating the effectiveness of the program established under this section including appropriate recommendations."

(b) The amendments made by subsection (a) shall apply only to services furnished by a hospital or skilled nursing facility for fiscal years beginning on and after the

first day of the first calendar month following enactment of this Act.

FEDERAL PARTICIPATION IN HOSPITAL CAPITAL EXPENDITURES

SEC. 4. (a) Section 1122 (b) of the Social Security Act is amended to read:

"(b) For purposes of this section, the State Health Planning and Development Agency designated under section 1521 of the Public Health Service Act shall serve as the designated planning agency."

(b) Section 1122 (c) is amended to read:

"(c) Expenses incurred by planning agencies shall be payable from—

"(i) funds in the Federal Hospital Insurance Trust Fund,

"(ii) funds in the Federal Supplementary Medical Insurance Trust Fund, and

"(iii) funds appropriated to carry out the health care provisions of the several titles of this Act,

in amounts as the Secretary finds results in a proper allocation. The Secretary shall transfer money between the funds as may be appropriate to settle accounts between them. The Secretary shall pay the planning agencies without requiring contribution of funds by any State or political subdivision."

(c) Section 1122 (d) is amended to read:

"(d) (1) Except as provided in paragraph (2), if the Secretary determines that—

"(A) neither the Health Systems Agency nor the designated planning agency had been notified of any proposed capital expenditure at least sixty days prior to obligation for the expenditure; or

"(B) (i) the designated planning agency had not approved the proposed expenditure; and

"(i) the designated planning agency had granted to the person proposing the capital expenditure an opportunity for a fair hearing with respect to the findings; then, in determining Federal payments under titles V, XVIII, and XIX for services furnished in the health care facility for which the capital expenditure is made, the Secretary shall not include any amount attributable to depreciation, interest on borrowed funds, a return on equity capital (in the case of proprietary facilities), other expenses related to the capital expenditure, or for direct operating costs, to the extent that they can be directly associated with the capital expenditure. In the case of a proposed capital expenditure in a standard metropolitan statistical area which encompasses more than one jurisdiction, that expenditure shall require approval of the designated planning agency of each jurisdiction who shall jointly review the proposal.

Where the designated planning agencies do not unanimously agree, the proposed expenditure shall be deemed disapproved; where the designated planning agencies do not act to approve or disapprove the proposed expenditure within one hundred and eighty days of submission of request for approval the proposed expenditure shall be deemed approved; any deemed approval or disapproval shall be subject to review and reversal by the Secretary following a request submitted to him within sixty days of the deemed approval or disapproval, for a review and reconsideration based upon the record. With respect to any organization which is reimbursed on a per capita, fixed fee, or negotiated rate basis, in determining the Federal payments to be made under titles V, XVIII, and XIX, the Secretary shall exclude an amount reasonably equivalent to the amount which would otherwise be excluded under this subsection if payment were made on other than a per capita, fixed fee, or negotiated rate basis.

"(2) If the Secretary, after submitting the matters involved to the advisory council, determines that an exclusion of expenses related to any capital expenditure would discourage the operation or expansion of any health care facility or health maintenance organization which has demonstrated to his satisfaction proof of its capability to provide comprehensive health care services (including institutional services) effectively and economically, or would be inconsistent with

effective organization and delivery of health services or effective administration of title V, XVIII, or XIX, he shall not exclude the expenses pursuant to paragraph (1)."

(d) Section 1122(g) of the Social Security Act is amended to read:

"(g) For purposes of this section, a 'capital expenditure' is one which, under generally accepted accounting principles, is not properly chargeable as an expense of operation and maintenance and which (1) exceeds $100,000, (2) changes the bed capacity of the facility, or (3) substantially changes the services of the facility, including conversion of existing beds to higher cost usage. The cost of studies, surveys, designs, plans, working drawings, specifications, and other activities essential to the acquisition, improvement, expansion, or replacement of the plant and equipment shall be included in determining whether the expenditure exceed $100,000.

(e) Section 1861(z) of the Social Security Act is amended to read:

"Institutional Planning

"(z) An overall plan and budget of a hospital, skilled nursing facility, or home health agency shall—

"(1) provide for an annual operating budget which includes all anticipated income and expenses related to items which would, under generally accepted accounting principles, be considered income and expense items

(except that nothing in this paragraph shall require that there be prepared, in connection with any budget an item-by-item identification of the components of each type of anticipated expenditure or income) ;

"(2) provide for a capital expenditures plan for at least a five-year period (including the year to which the operating budget applies) which identifies in detail the sources of financing and the objectives of each anticipated expenditure in excess of $100,000 related to the acquisition of land, improvement of land, buildings, and equipment, and the replacement, modernization, and expansion of the buildings and equipment, and which would, under generally accepted accounting principles, be considered capital items. The capital expenditures plan shall be a matter of public record and available in readily accessible form and fashion;

"(3) provide for annual review and updating; and

"(4) be prepared, under the direction of the governing body of the institution or agency, by a committee consisting of representatives of the governing body, administrative staff, and medical staff (if any) of the institution or agency."

AGREEMENT BY PHYSICIANS TO ACCEPT ASSIGNMENTS

SEC. 10. (a) (1) Title XVIII of the Social Security Act is amended by adding the following section:

"AGREEMENTS OF PHYSICIANS TO ACCEPT ASSIGNMENT

"SEC. 1868. (a) For purposes of this section the term 'participating physician' means a doctor of medicine or osteopathy who has in effect an agreement by which he agrees to accept an assignment of claim (as provided for in section 1842(b)(3)(B)(ii)) for each physicians' service (other than those excluded from coverage by section 1862) performed by him in the United States for an individual enrolled under this part. The assignment shall be in a form prescribed by the Secretary. The agreement may be terminated by either party upon thirty days' notice to the other, filed in a manner prescribed by the Secretary.

"(b) To expedite processing of claims from participating physicians, the Secretary shall establish procedures and develop appropriate forms under which—

"(1) each physician will submit his claims on one of alternative simplified approved bases, including multiple listing of patients, and the Secretary shall act to assure that these claims are processed expeditiously, and

"(2) The physician shall obtain from each patient enrolled under this part (except in cases where the Secretary finds it impractical for the patient to furnish it), and shall make available at the Secretary's request, a signed statement by which the patient: (i) agrees to make an assignment with respect to all services fur-

nished by the physician; and (ii) authorizes the release of any medical information needed to review claims submitted by the physician.

"(c) (1) Participating physicians shall be paid administrative cost-savings allowances (as specified below in this subsection) in addition to the reasonable charges that are payable.

"(2) The administrative cost-savings allowance shall equal $1 and shall be paid to the participating physician for each claim he submits in accordance with the simplified billing procedure referred to in subparagraph (b). and these payments shall be treated as an administrative expense to the medical insurance program: *Provided, however,* That:

"(A) not more than $1 shall be payable to a physician for claims for services furnished to any particular patient within any seven-day period; and

"(B) no administrative cost-savings allowance shall be payable for services performed for a hospital inpatient or outpatient unless:

"(i) the services are surgical services, anesthesia services, or services performed by a physician who, as an attending or consulting physician who, has personally examined the patient and whose office or regular place of practice is located outside a hospital, and

"(ii) the physician ordinarily bills directly (and not through such hospital) for his services;

"(C) no administrative cost-savings allowance shall be payable for services which consist solely of laboratory or X-ray services which are for hospital inpatients or outpatients or are performed outside the office of the participating physician.".

(b) The amendments made by paragraph (1) shall become effective July 1, 1978.

CRITERIA FOR DETERMINING REASONABLE CHARGE FOR PHYSICIANS' SERVICES

SEC. 11. (a) (1) So much of section 1842 (b) (3) of the Social Security Act as follows the first sentence is amended to read:

"(3A) (A) In determining the reasonable charge for services for purposes of paragraph (3) (including any hospital-associated physicians), there shall be taken into consideration the customary charges for similar services generally made by the physician or other person furnishing such services, as well as the prevailing charges in the locality for similar services.

"(B) (i) Except as otherwise provided in clause (iii), no charge may be determined to be reasonable in the case of bills submitted or requests for payment made under this part after December 31, 1970, if it exceeds the higher of (I)

the prevailing charge recognized by the carrier and found acceptable by the Secretary for similar services in the same locality in administering this part on December 31, 1970, or (II) the prevailing charge level that, on the basis of statistical data and methodology acceptable to the Secretary, would cover 75 per centum of the customary charges made for similar services in the same locality during the last preceding calendar year elapsing prior to the start of the fiscal year in which the bill is submitted or the request for payment is made.

"(ii) In the case of physician services the prevailing charge level determined for purposes of clause (i) (II) for any fiscal year beginning after June 30, 1973, may not (except as otherwise provided in clause (iii)) exceed (in the aggregate) the level determined under such clause for the fiscal year ending June 30, 1973, except to the extent that the Secretary finds, on the basis of appropriate economics index data, that such higher level is justified by economic changes. Moreover, for any fiscal year beginning after June 30, 1978, no prevailing charge level for physicians' services shall be increased to the extent that it would exceed by more than one-third the statewide prevailing charge level (as determined under subparagraph (E)) for that service.

"(iii) Notwithstanding the provisions of clauses (i) and (ii) of this subparagraph, the prevailing charge level in the

case of a physician service in a particular locality determined pursuant to such clauses for the fiscal year beginning July 1, 1975, shall, if lower than the prevailing charge level for the fiscal year ending June 30, 1975, in the case of a similar physician service in the same locality by reason of the application of economic index data, be raised to such prevailing charge level for the fiscal year ending June 30, 1975.

"(C) In the case of medical services, supplies, and equipment (including equipment servicing) that, in the judgment of the Secretary, do not generally vary significantly in quality from one supplier to another, the charges incurred after December 31, 1972, determined to be reasonable may not exceed the lowest charge levels at which such services, supplies, and equipment are widely and consistently available in a locality except to the extent and under circumstances specified by the Secretary.

"(D) The requirement in paragraph (3) (B) that a bill be submitted or request for payment be made by the close of the following calendar year shall not apply if (i) failure to submit the bill or request the payment by the close of such year is due to the error or misrepresentation or an officer, employee, fiscal intermediary, carrier, or agent of the Department of Health, Education, and Welfare performing functions under this title and acting within the scope of his or its authority, and (ii) the bill is submitted or the payment

is requested promptly after such error or misrepresentation is eliminated or corrected.

"(E) The Secretary shall determine separate statewide prevailing charge levels for each State that, on the basis of statistical data and methodology acceptable to the Secretary, would cover 50 percent of the customary charges made for similar services in the State during the last preceding calendar year elapsing prior to the start of the fiscal year in which the bill is submitted or the request for payment is made.

"(F) Notwithstanding any other provision of this paragraph, any charge for any particular service or procedure performed by a doctor of medicine or osteopathy shall be regarded as a reasonable charge if—

"(i) the service or procedure is performed in an area which the Secretary has designated as a physician shortage area,

"the physician has a regular practice in the physician shortage area,

"(iii) the charge does not exceed the prevailing charge level as determined under subparagraph (B), and

"(iv) the charge does not exceed the physician's customary charge.".

(2) The amendment made by paragraph (1) shall take effect upon enactment.

HOSPITAL-ASSOCIATED PHYSICIANS

SEC. 12. (a) (1) Section 1861 (q) of the Social Security Act is amended by adding "(1)" immediately after "(q)" and by adding, immediately before the period at the end thereof, the following: "; except that the term does not include any service that a physician may perform as an educator, an executive, or a researcher; or any professional patient care service unless the service (A) is personally performed by or personally directed by a physician for the benefit of the patient and (B) is of such nature that its performance by a physician is customary and appropriate".

(2) Section 1861 (q) is amended by adding the following paragraphs at the end:

"(2) In the case of anesthesiology services, a procedure would be considered to be 'personally performed' in its entirety by a physician where the physician performs the following activities:

"(A) preanesthetic evaluation of the patient;

"(B) prescription of the anesthesia plan;

"(C) personal participation in the most demanding procedures in this plan, including those of induction and emergence and assuring that a qualified individual, who need not be his employee, performs any of the

less demanding procedures which the physician does not personally perform;

"(D) following the course of anesthesia administration at frequent intervals;

"(E) remaining physically available for the immediate diagnosis and treatment of emergencies; and

"(F) providing indicated postanesthesia care:

Provided, however, That during the performance of the activities described in subparagraphs (C), (D), and (E), the physician is not responsible for the care of more than one other patient. Where a physician performs the activities described in subparagraphs (A), (B), (D), and (E) and another individual performs the activities described in subparagraph (C), the physician will be deemed to have personally directed the services if he was responsible for no more than four patients while performing the activities described in subparagraphs (D) and (E) and the reasonable charge for his personal direction shall not exceed one-half the amount that would have been payable if he had personally performed the procedure in its entirety.

"(3) Pathology services shall be considered 'physicians' services' to patients only where the physician personally performs acts or makes decisions with respect to a patient's diagnosis or treatment which require the exercise of medical judgment. These include operating room and clinical con-

sultations, the required interpretation of the significance of any material or data derived from a human being, the aspiration or removal of marrow or other materials, and the administration of test materials or isotopes. Such professional services shall not include professional services such as: the performance of autopsies; and services performed in carrying out responsibilities for supervision, quality control, and for various other aspects of a clinical laboratory's operations that are customarily performed by nonphysician personnel.

(3) Section 1861(b) of such Act is amended—

(A) by striking out "or" at the end of paragraph (6),

(B) by striking out the period at the end of paragraph (7) and inserting "; or", and

(C) by adding at the end the following paragraph:

"(8) a physician, if the services provided are not physicians' services (within the meaning of subsection (q))."

(b)(1) Section 1861(s) of the Social Security Act is amended by adding at the end: "The term 'medical and other health services' shall not include services described in paragraphs (2)(A) and (3) if furnished to inpatients of a provider of services unless the Secretary finds that, because of the size of the hospital and the part-time nature of the services or for some other reason acceptable to him, it would

be less efficient to have the services furnished by the hospital (or by others under arrangement with them made by the hospital) than to have them furnished by another party.".

(2) Section 1842(b)(3A) of such Act, as added by section 20 of this Act, is amended by adding:

"(G) The charge for a physician's or other person's services and items which are related to the income or receipts of a hospital or hospital subdivision shall not be considered in determining his customary charge to the extent that the charge exceeds an amount equal to the salary which would reasonably have been paid for the service (together with any additional costs that would have been incurred by the hospital) to the physician performing it if it had been performed in an employment relationship with the hospital plus the cost of other expenses (including a reasonable allowance for travel-time and other reasonable types of expense related to any differences in acceptable methods of organization for the provision of services) incurred by the physician, as the Secretary may determine to be appropriate.".

(c) Section 1861(v) of the Social Security Act is amended by adding:

"(8)(A) Where physicians' services are furnished under an arrangement (including an arrangement under which the physician performing the services is compensated

on a basis related to the amount of the income or receipts of the hospital or any department or other subdivision) with a hospital or medical school, the amount included in any payment to the hospital under this title as the reasonable cost of the services (as furnished under the arrangement) shall not exceed an amount equal to the salary which would reasonably have been paid for the services (together with any additional costs that would have been incurred by the hospital) to the physician performing them if they had been performed in an employment relationship with the hospital (rather than under such arrangement) plus the cost of other expenses (including a reasonable allowance for traveltime and other reasonable types of expense related to any differences in acceptable methods of organization for the provision of the services) incurred by the physician, as the Secretary may determine to be appropriate.".

(d) (1) Section 1833 (a) (1) (B) of the Social Security Act is amended by inserting "(except as provided in subsection (h))" immediately after "amounts paid shall".

(2) Section 1833 (b) (2) of such Act is amended by inserting "(except as otherwise provided in subsection (h))" immediately after "amount paid shall".

(3) Section 1833 of such Act is amended by adding:

"(h) The provisions of subsection (a) (1) (B) and clause (2) of the first sentence of subsection (b) shall not

apply to any physician unless he has entered into an agreement with the Secretary under which he agrees to be compensated for all such services on the basis of an assignment the terms of which are described in section 1842 (b) (3) (B) (ii).".

(e) The amendments made by this section shall, except those made by subsection (d), apply to services furnished in accounting periods of the hospital which begin after the month following the month of enactment of this Act. The amendment made by subsection (d) shall be effective July 1, 1978.

PAYMENT FOR CERTAIN ANTIGENS UNDER PART B OF MEDICARE

SEC. 13. (a) Section 1861 (s) (2) of the Social Security Act is amended—

(1) by striking out "and" at the end of clause (C),

(2) by inserting "and" at the end of clause (D), and

(3) by adding after clause (D) the following new clause:

"(E) antigens (subject to reasonable quantity limitations determined by the Secretary) prepared by an allergist for a particular patient, including antigens he prepares which are forwarded to another qualified per-

son for administration to the patient by or under the supervision of another physician;".

(b) Subsection (a) shall apply to items furnished after the month of enactment of this Act.

PAYMENT UNDER MEDICARE OF CERTAIN PHYSICIANS' FEES ON ACCOUNT OF SERVICES FURNISHED TO A DECEASED INDIVIDUAL

SEC. 14. (a) Section 1870(f) of the Social Security Act is amended, in the matter following clause (2) thereof, by—

(1) inserting "(A)" immediately after ", and only if", and

(2) by inserting immediately before the period the following: ", or (B) the spouse or other legally designated representative of such individual requests (in such form and manner as the Secretary shall by regulations prescribe) that payment for such services without regard to clause (A)".

(b) Subsection (a) shall apply to payments made after the month of enactment.

USE OF APPROVED RELATIVE VALUE SCHEDULE

SEC. 15. (a) To provide common language describing the various kinds and levels of medical services which may be reimbursed under titles V, XVIII, and XIX, of the Social Security Act, the Secretary of Health, Education, and Wel-

fare shall establish a system of procedural terminology, including definitions of the terms. The system shall be developed by the Health Care Financing Administration with the advice of other large health care purchasers, representatives of professional groups and other interested parties. In developing the system, the Health Care Financing Administration shall consider among other things, the experience of third parties in using existing terminology systems in terms of: implications for administrative and program costs; simplicity and lack of ambiguity; and the degree of acceptance and use.

(b) Upon development of a proposed system of procedural terminology and its approval by the Secretary of Health, Education, and Welfare, it shall be published in the Federal Register. Interested parties shall have not less than six months in which to comment on the proposed system and to recommend relative values to the Secretary for the procedures and services designated by the terms. Comments and proposals shall be supported by information and documentation specified by the Secretary.

(c) The good faith preparation of a relative value schedule or its submission to the Secretary by an association of health practitioners solely in response to a request of the Secretary as authorized under this section shall not in itself be considered a violation of any consent decree by which

an association has waived its right to make recommendations concerning fees: *Provided,* That the proposed relative value schedule shall not be disclosed to anyone other than those persons actually preparing it or their counsel until it is made public by the Secretary.

(d) The Health Care Financing Administration shall review materials submitted under this section and shall recommend that the Secretary adopt a specific terminology system and its relative values for use by carriers in calculating reasonable charges under title XVIII of the Social Security Act, but only after:

(1) Interested parties have been given an opportunity to comment and any comments have been considered;

(2) Statistical analyses have been conducted assessing the economic impact of the relative values on the physicians in various specialties, geographic areas and types of practice, and on the potential liability of the program established by part B of title XVIII of the Social Security Act;

(3) It has been determined that the proposed terminology and related definitions are unambiguous, practical, and easy to evaluate in actual clinical situations and that the unit values assigned generally reflect the

relative time and effort required to perform various procedures and services.

(4) That the use of the proposed system will enhance the administration of the Federal health care financing programs.

(e) A system of terminology, definitions, and their relative values, as approved by the Secretary, shall be periodically reviewed by him and may be modified. An approved system (as amended by any modification of the Secretary) may subsequently be used by any organization or person for purposes other than those of this Act. Nothing in this section shall be considered to bar the Secretary from adopting a uniform system of procedural terminology in situations where a relative value schedule has not been approved.

HOSPITAL PROVIDERS OF LONG-TERM CARE SERVICES

SEC. 20. (a) Section 1861 of the Social Security Act is amended by adding after subsection (aa) (as added by section 10 (b) of this Act) the following:

"Hospital Providers of Extended Care Services

"(bb) (1) (A) Any hospital (other than a hospital which has in effect a waiver of the requirement imposed by subsection (e) (5)) which has an agreement under section 1866 may (subject to paragraph (2)) enter into an agreement with the Secretary under which its inpatient hospital

facilities may be used for the furnishing of services of the type which, if furnished by a skilled nursing facility, would constitute post-hospital extended care services.

"(B) (i) Notwithstanding any other provision of this title, payment to any hospital for services furnished under an agreement entered into under this subsection shall be based upon the reasonable cost of the services as determined under this subparagraph.

"(ii) The reasonable cost of the services will consist of the reasonable cost of routine services and ancillary services. The reasonable cost of routine services furnished during any calendar year by a hospital under an agreement under this subsection shall equal the product of the number of patient-days during the year for which the services were furnished and the average reasonable cost per patient-day. The average reasonable cost per patient-day shall be established as the average rate per patient-day paid for routine services during the previous calendar year under title XIX to skilled nursing facilities located in the State in which the hospital is located and which have agreements entered into under section 1902a(28). The reasonable cost of ancillary services shall be determined in the same manner as the reasonable cost of ancillary services provided for inpatient hospital services.

"(2) (A) The Secretary shall not enter into an agreement under this subsection with any hospital unless—

"(i) for a period specified by the Secretary (not less than twelve months) which immediately precedes the date the agreement is entered into, the hospital has had an average daily occupancy rate of less than 60 percent,

"(ii) the hospital is located in a rural area and has less than 50 beds, and

"(iii) the hospital has been granted a certificate of need for the provision of long-term care services from the agency of the State (which has been designated as the State health planning and development agency under an agreement pursuant to section 1521 of the Public Health Service Act) in which the hospital is located.

"(3) An agreement with a hospital entered into under this section shall, except as otherwise provided under regulations of the Secretary, be of the same duration and subject to termination on the same conditions as are agreements with skilled nursing facilities under section 1866, unless the hospital fails to satisfy the requirements defined in paragraph (2) (A) of this subsection and shall, where not inconsistent with any provision of this subsection, impose the same duties, responsibilities, conditions, and limitations,

as those imposed under such agreements entered into under section 1866; except that no such agreement with any hospital shall be in effect for any period during which the hospital does not have in effect an agreement under section 1866, or where there is in effect for the hospital a waiver of the requirement imposed by subsection (e) (5). A hospital whose agreement has been terminated shall not be eligible to undertake a new agreement until a two-year period has elapsed from the termination date.

"(4) Any agreement with a hospital under this subsection shall provide that payment for services will be made only for services for which payment would be made as post-hospital extended care services, if those services had been furnished by a skilled nursing facility under an agreement entered into under section 1866; and any individual who is furnished services, for which payment may be made under an agreement, shall, for purposes of this title (other than this subsection), be deemed to have received post-hospital extended care services in like manner and to the same extent as if the services furnished to him had been post-hospital extended care services furnished by a skilled nursing facility under an agreement under section 1866.

"(5) During a period for which a hospital has in effect an agreement under this subsection, in order to allocate routine costs between hospital and long-term care services for

purposes of determining payment for inpatient hospital services (including the application of reimbursement limits specified in section 1861 (aa)), the total reimbursement received for routine services from all classes of long-term care patients, including title XVIII, title XIX, and private pay patients, shall be subtracted from the hospital's total routine costs before calculations are made to determine title XVIII reimbursement for routine hospital services.

"(6) During any period during which an agreement is in effect with a hospital under this subsection, the hospital shall, for services furnished by it under the agreement, be considered to satisfy the requirements, otherwise required, of a skilled nursing facility for purposes of the following provisions: sections 1814 (a) (2) (C), 1814 (a) (6), 1814 (a) (7), 1814 (h), 1861 (a) (2), 1861 (i), 1861 (j) (except 1861 (j) (12)), and 1861 (n); and the Secretary shall specify any other provisions of this Act where the hospital may be considered as a skilled nursing facility.

"(7) (c) Within three years after enactment, the Secretary shall provide a report to the Congress containing an evaluation of the program established under this subsection concerning:

"(1) The extent and effect of the agreements on availability and effective and economical provision of long-term care services,

"(2) whether the program should be continued, and

"(3) whether eligibility should be extended to other hospitals, regardless of bed size or geographic location, where there is a shortage of long-term care beds.".

(b) Title XIX of such Act is amended by adding at the end thereof the following new section:

"HOSPITAL PROVIDERS OF SKILLED NURSING AND INTERMEDIATE CARE SERVICES

"SEC. 1911. (a) Notwithstanding any other provision of this title, payment may be made, in accordance with this section, under an approved State plan for skilled nursing services and intermediate care services furnished by a hospital which has in effect an agreement under section 1861 (bb).

"(b) (1) Payment to any such hospital, for any skilled nursing or intermediate care services furnished, shall be at a rate equal to the average rate per patient-pay paid for routine services during the previous calendar year under this title to skilled nursing and intermediate care facilities located in the State in which the hospital is located. The reasonable cost of ancillary services shall be determined in the same manner as the reasonable cost of ancillary services provided for inpatient hospital services.

"(2) With respect to any period for which a hospital has an agreement under section 1861(bb), in order to allocate routine costs between hospital and long-term care services, the total reimbursement for routine services received from all classes of long-term care patients, including title XVIII, title XIX, and private pay patients, shall be subtracted from the hospital total routine costs before calculations are made to determine title XIX reimbursement for routine hospital services.".

(c) The amendments made by this section shall become effective on the date on which final regulations, promulgated by the Secretary to implement the amendments, are issued; and those regulations shall be issued not later than the first day of the sixth calendar month following the month in which this Act is enacted.

REIMBURSEMENT RATES UNDER MEDICAID FOR SKILLED NURSING AND INTERMEDIATE CARE FACILITIES

SEC. 21. Section 1902(a)(13)(E) of the Social Security Act is amended by inserting "(and which may, at the option of the State, include a reasonable profit for the facility in the form of: (a) fixed per diem amounts or, (b) incentive payments related to efficient performance, or (c) a rate of return on net equity)" immediately after "cost related basis".

MEDICAID CERTIFICATION AND APPROVAL OF SKILLED NURSING AND INTERMEDIATE CARE FACILITIES

SEC. 22. (a) Section 1910 of the Social Security Act is amended to read:

"CERTIFICATION AND APPROVAL OF SKILLED NURSING AND INTERMEDIATE CARE FACILITIES

"SEC. 1910. (a) The Secretary shall make an agreement with any State which is willing and able to do so whereby the State health agency or other appropriate State or local agencies (whichever are utilized by the Secretary pursuant to section 1864(a)) will be utilized to recommend to him whether an institution in the State qualifies as a skilled nursing facility (for purposes of section 1902(a)(28)) or an intermediate care facility (for purposes of section 1905(c)).

"(b) The Secretary shall advise the State agency administering the medical assistance plan of his approval or disapproval of any institution certified to him as a qualified skilled nursing or intermediate care facility for purposes of section 1902(a)(28) and specify for each institution the period (not to exceed twelve months) for which approval is granted, except that the Secretary may extend that term for up to two months, where the health and safety of patients will not be jeopardized, if he finds that an extension is necessary to prevent irreparable harm to the facility or

hardship to the facility's patients or if he finds it impracticable within the twelve-month period to determine whether the facility is complying with the provisions of this title and applicable regulations. The State agency may upon approval of the Secretary enter into an agreement with any skilled nursing or intermediate care facility for the specified approval period.

"(c) The Secretary may cancel approval of any skilled nursing or intermediate care facility at any time if he finds that a facility fails to meet the requirements contained in section 1902(a)(28) or section 1905(c), or if he finds grounds for termination of his agreement with the facility pursuant to section 1866(b). In that event the Secretary shall notify the State agency and the skilled nursing or intermediate care facility that approval of eligibility of the facility to participate in the programs established by this title and title XVIII shall be terminated at a time specified by the Secretary. The approval of eligibility of any such facility to participate in the programs may not be reinstated unless the Secretary finds that the reason for termination has been removed and there is reasonable assurance that it will not recur.

"(d) Effective July 1, 1978, no payment may be made to any State under this title for skilled nursing or intermediate care facility services furnished by any facility—

"(1) which does not have in effect an agreement with the State agency pursuant to subsection (b), or

"(2) whose approval of eligibility to participate in the programs established by this title or title XVIII has been terminated by the Secretary and has not been reinstated, except that payment may be made for up to thirty days for skilled nursing or intermediate care facility services furnished to any eligible individual who was admitted to the facility prior to the effective date of the termination.".

"(e) Any skilled nursing facility or intermediate care facility which is dissatisfied with any determination by the Secretary that it no longer qualifies as a skilled nursing facility or intermediate care facility for purposes of this title shall be entitled to a hearing by the Secretary to the same extent as is provided in section 205(b) and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g). Any agreement between such facility and the State agency shall remain in effect until the period for filing a request for a hearing has expired or, if a request has been filed, until a decision has been made by the Secretary: *Provided, however,* That the agreement shall not be extended if the Secretary makes a written determination, specifying the reasons therefor, that the continuation of provider status constitutes an immediate and serious

threat to the health and safety of patients, and if the Secretary certifies that the facility has been notified of its deficiencies and has failed to correct them.".

(b) Section 1869(c) of the Social Security Act is amended by adding at the end the following sentence: "If the Secretary's determination terminates a provider with an existing agreement pursuant to section 1866(b)(2), or if that determination consists of a refusal to renew an existing provider agreement, the provider's agreement shall remain in effect until the period for filing a request for a hearing has expired or, if a request has been filed, until a final decision has been made by the Secretary: *Provided, however*, That the agreement shall not be extended if the Secretary makes a written determination, specifying the reasons therefor, that the continuation of provider status constitutes an immediate and serious threat to the health and safety of patients and if the Secretary certifies that the provider has been notified of such deficiencies and has failed to correct them.".

(c) The amendments made by this section shall become effective on the date on which final regulations, promulgated by the Secretary to implement the amendments, are issued; and those regulations shall be issued not later than

the first day of the sixth calendar month following the month in which this Act is enacted.

VISITS AWAY FROM INSTITUTION BY PATIENTS OF SKILLED NURSING OR INTERMEDIATE CARE FACILITIES

SEC. 23. Section 1903 of the Social Security Act is amended by adding:

"(l) In the administration of this title, the fact that an individual who is an inpatient of a skilled nursing or intermediate care facility leaves to make visits outside the facility shall not conclusively indicate that he does not need services which the facility is designed to provide; however, the frequency and length of visits away shall be considered, together with other evidence, in determining whether the individual is in need of the facility's services.".

ESTABLISHMENT OF HEALTH CARE FINANCING ADMINISTRATION

SEC. 30. (a) Section 702 of the Social Security Act is amended—

(1) by inserting "(a)" immediately after "SEC. 702.", and

(2) by adding at the end the following subsection:

"(b) The Secretary shall establish, within the Department of Health, Education, and Welfare, a separate organization to be known as the Health Care Financing Administration (which shall include the functions and per-

sonnel of administrative entities known as of January 1, 1977 as the 'Bureau of Health Insurance', the 'Medical Services Administration', the 'Bureau of Quality Assurance' (including the National Professional Standards Review Council), and the 'Office of Long-Term Care' and related research and statistical units (including the Division of Health Insurance Studies of the Social Security Administration) which shall be under the direction of the Assistant Secretary for Health Care Financing, who shall report directly to the Secretary and who shall have policy and administrative responsibility (including policy and administrative responsibility with respect to health care standards and certification requirements as they apply to practitioners and institutions) for the programs established by titles XVIII and XIX, part B of title XI, for the renal disease program established by section 226 and any other health care financing programs as may be established under this Act. The Assistant Secretary may not have any other duties or functions assigned to him which would prevent him from carrying out the duties required under the preceding sentence on a full-time basis.

(b) (1) There shall be in the Department of Health, Education, and Welfare an Assistant Secretary for Health Care Financing, who shall be appointed by the President, by and with the advice and consent of the Senate.

(2) Section 5315 of title 5, United States Code, is amended in paragraph (17) by striking out "(5)" and inserting in lieu thereof "(6)".

STATE MEDICAID ADMINISTRATION

SEC. 31. (a) Section 1902 (a) is amended by adding at the end the following:

"(37) provide—

"(A) for making eligibility determinations on the basis of applications for coverage, within forty-five days of the date of application for all individuals: (i) receiving aid or assistance (or who except for income and resources would be eligible for aid or assistance) under a plan of the State approved under title IV, part A, (ii) receiving aid or assistance (or who except for income and resources would be eligible for assistance) under any plan of the State approved under title I, X, or XVI (for the aged and the blind), or (iii) with respect to whom supplemental security income benefits are being paid (or who would except for income and resources be eligible to have paid with respect to them supplemental security income benefits) under title XVI on the basis of age or blindness; and

"(B) for making eligibility determina-

tions based upon applications for coverage, within sixty days of application for all individuals: (i) receiving aid or assistance (or who except for income and resources would be eligible for aid or assistance) on the basis of disability under any plan of the State approved under title XIV or XVI, or (ii) for whom supplemental security income benefits are being paid (or who would except for income and resources be eligible to have paid to them supplemental security income benefits) under title XVI based upon disability;

"(C) for making redeterminations of eligibility for persons specified in subparagraphs (A) and (B): (i) when required based upon information the agency has previously obtained on anticipated changes in the individual's situation, (ii) within thirty days after receiving information on changes in an individual's circumstances which may affect his eligibility, and (iii) periodically but not less often than every six months for persons specified in subparagraph (A) (i), and not less often than annually for persons specified in subparagraph (A) (ii) and (A) (iii);

"(38) establish procedures to assure accurate determinations of eligibility and provide that the error

rate for eligibility determinations made on or after October 1, 1977, shall not exceed the rate specified in section 1911 (b) ; and

"(39) establish payment procedures to assure that (A) 95 percent of claims for which no further written information or substantiation is required to make payment, be paid within thirty days of receipt of the claim from a provider, and that 99 percent of such claims be paid within ninety days, and (B) both prepayment and postpayment claims review procedures are performed, including—

"(i) review, on a reasonable sample or more extensive basis, to determine the accuracy of data submitted and processed;

"(ii) review to determine that the provider is a participating provider;

"(iii) review to determine whether the service is covered under the State's plan;

"(iv) review to determine whether the recipient is eligible;

"(v) review of care and services provided where such review has not been assumed by an organization designated by the Secretary under part B of title XI of this Act;

"(vi) review to determine that payments made do not exceed those allowable;

"(vii) review to determine and recover any third party liability;

"(viii) review which reasonably safeguards against duplicate billing.".

(b) Section 1902(a)(6) is amended by adding the following at the end: "the reports are to be accurate and filed within sixty days following the close of the reporting period for monthly and quarterly reports, and within one hundred and five days following the close of reporting periods for yearly reports;".

(c) Amend section 1903 by adding at the end the following subsection:

"(n)(1) Effective with each calendar quarter beginning October 1, 1978 the amount paid to each State under paragraphs (a)(2), (a)(3), and (a)(6) shall be reduced or terminated unless the State demonstrates to the Secretary that—

"(A) 95 percent of eligibility determinations are made within the time periods specified under section 1902(a)(37)(A) and (B), except that in determining whether a State has met the requirements of this paragraph there shall not be included eligibility determinations for persons whose eligibility is determined

under State plans approved under title I, X, XIV, XVI, or part A of title IV, or by the Secretary under section 1634;

"(B) the State's eligibility determination error rate does not exceed the rate specified in section 1911(b), except that in determining whether a State has met the requirements of this paragraph there shall not be included error rates for those persons whose eligibility is determined under a State plan approved under titles I, X, XIV, XVI, or part A of title IV or by the Secretary under section 1634;

"(C) the State is processing claims for payment within the time period specified in section 1902(a)(39)(A) and applying prepayment and postpayment claims review procedures specified in section 1902(a)(39)(B); and

"(D) the State is making timely and complete reports to the Secretary on the operation of its medical assistance program within the time period including the information specified in section 1902(a)(6).

"(2) The Secretary shall conduct an onsite survey in each State, at least annually, of State performance in each category under paragraph (1). The methodology and procedures (which may involve onsite evaluation) employed, including procedures for any necessary followup of any de-

ficiencies, must be formally approved by the Comptroller General of the United States;

"(3) Any State which fails to meet one or more of the requirements specified in subparagraph (A), (B), (C) or (D) of paragraph (1) shall be formally notified within thirty days of the survey of the deficiencies. The State shall be given an appropriate period of time, not to exceed six months, to correct the deficiencies;

"(4) Any State which fails to correct deficiencies within the time period specified under paragraph (3) as determined by the Secretary shall be notified and subject to a reduction in Federal matching as specified in paragraph (5) beginning on the first day of the first calendar quarter following the date on which the Secretary specified the deficiencies must be corrected under paragraph (3);

"(5) (A) Where the Secretary finds that a State failed to meet the requirements of one of the subparagraphs (A), (B), (C), or (D) of paragraph (1) and has not made corrections required under paragraph (4), Federal matching shall be reduced to 50 percent of what the State would otherwise receive under subsections (a) (2), (a) (3), and (a) (6).

"(B) Where the Secretary determines that a State failed to meet requirements of two or more of subparagraphs (A), (B), (C), or (D) of paragraph (1) and that it has

not made the corrections as determined under paragraph (4), its Federal matching shall be terminated under subsections (a) (2), (a) (3), and (a) (6).

"(6) (A) Any State which had had Federal matching reduced or terminated under paragraph (5) shall continue to have the matching reduced or terminated until the Secretary determines that the deficiencies have been corrected.

"(B) A State determined to have corrected all categories specified as deficient shall be entitled to the matching rate specified in subsections (a) (2), (a) (3), and (a) (6) beginning on the first day of the calendar quarter in which the corrections were made.

"(C) In a State where matching has been terminated under subsections (a) (2), (a) (3), and (a) (6) as provided under subparagraph (5) (B) and where the Secretary determines that deficiencies continue in only one of the four specified categories, that State shall, beginning on the first day of the calendar quarter in which the correction was made, be entitled to the reduced matching rate specified in subparagraph (5) (A).

"(7) Where a State is determined by the Secretary based upon an onsite evaluation to substantially exceed the requirements of at least two of subparagraphs (A), (B), (C), or (D) of paragraph (1) and meets the requirements of the remaining subparagraphs, that State shall be notified

and entitled to a Federal matching rate under subsection (a) (6) of 75 percent and that amount shall apply in each calendar quarter for which the Secretary finds the State continues to meet the requirements of this paragraph;

"(8) The Secretary shall provide or arrange for the reasonable provision of technical assistance by experienced and qualified Federal, State, or local governmental personnel to any State which requests assistance in meeting the requirements of paragraph (1).

"(9) If the Secretary notifies a State of deficiencies, or a reduction, termination, or increase in Federal matching, simultaneous notification shall also be made to the Governor of the State, and the respective chairmen of the legislative and appropriation committees of that State's legislature having jurisdiction over the medical assistance program authorized under this title.".

(d) Title XIX of the Social Security Act is amended by adding at the end the following new sections:

"QUALITY CONTROL

"SEC. 1911. The Secretary shall—

"(a) determine the eligibility error rates, including cases incorrectly approved and cases incorrectly denied, for each State for the six-month period commencing with the first calendar quarter beginning six months following enactment of this title. The Secretary shall

exclude those cases for which the most recent determination or redetermination of eligibility was correctly made, but where eligibility status subsequently changed, if the State meets the time requirements specified in section 1902 (a) (37);

"(b) establish a State classification system, with States classified according to: (1) whether the State provides medical assistance for persons specified in section 1902 (a) (10) (C); and (2) population, with those States with greater populations in one grouping and those States with lesser populations in another;

"(c) establish an error rate defined as the rate which equals the 75th percentile of the rates reported by the States under paragraph (a) for each class of States under (b).

"REPORT BY THE SECRETARY

"SEC. 1912. The Secretary shall prepare a biannual report (beginning with fiscal year 1978) on the characteristics of the State programs of medical assistance financed under this title, including, at least (1) a description of the scope and duration of benefits available in each State, (2) a description of eligibility criteria for all groups eligible for medical assistance, (3) specification of the reimbursement methodology for payments under the State program for the major types of services, and (4) a listing of all fiscal agents,

insurers and health maintenance organizations contracted with for administration of the program. Such report shall be submitted to the Committee on Finance of the Senate and the Committee on Interstate and Foreign Commerce of the House of Representatives no later than six months following the close of the fiscal year."

REGULATIONS OF THE SECRETARY

SEC. 32. (a) (1) Section 1102 of the Social Security Act is amended—

(A) by inserting "(a)" immediately after "SEC. 1102.", and

(B) by adding at the end the following subsection:

"(b) Whenever the Secretary, in compliance with requirements imposed by law, has published in the Federal Register general notice of any proposed rule or regulation to be promulgated by him, that notice shall indicate whether prompt promulgation is urgent. Where the notice indicates that prompt promulgation is urgent, the rule or regulation shall become effective within sixty days after publication of the notice; in any other case, the rule or regulation shall become effective without regard to the provisions of this subsection in the manner prescribed by applicable provisions of law.".

(2) Amendments made by paragraph (1) shall be effective for proposed rules published in the Federal Register

on and after the first day of the first calendar month which begins more than thirty days after the date of enactment of this Act.

(b) Except as otherwise specified in this Act or in a provision of law which is enacted or amended by this Act, any regulation of the Secretary of Health, Education, and Welfare (hereinafter in this section referred to as the "Secretary"), which is necessary or appropriate to implement any provision of this Act or any other provision of law which is enacted or modified by this Act, shall, subject to paragraph (2), be promulgated so as to become effective not later than the first day of the thirteenth month following the month in which this Act is enacted.

REPEAL OF SECTION 1867

SEC. 33. Section 1867 of the Social Security Act is hereby repealed.

PROCEDURES FOR DETERMINING REASONABLE COST AND REASONABLE CHARGE

SEC. 40. (a) (1) In determining the amount of any payment under title XVIII, under a program established under title V, or under a State plan approved under title XIX, when the payment is based upon the reasonable cost or reasonable charge, no element comprising any part of the cost or charge shall be considered to be reasonable if, and to the extent that, that element is—

(A) a commission, finder's fee, or for a similar arrangement, or

(B) an amount payable for any facility (or part or activity thereof) under any rental or lease arrangement

which is, directly or indirectly, determined, wholly or in part as a percentage, fraction, or portion of the charge or cost attributed to any health service (other than the element) or any health service including, but not limited to, the element.

AMBULANCE SERVICE

SEC. 41. (a) Section 1861 (s) (7) of the Social Security Act is amended by inserting:

"(Including ambulance service to the nearest hospital which is: (a) adequately equipped and (b) has medical personnel qualified to deal with, and available for the treatment of, the individual's illness, injury, or condition)" immediately after "ambulance service".

(b) The amendment made by subsection (a) shall apply to services furnished on and after the first day of the first calendar month which begins after the date of enactment of this Act.

GRANTS TO REGIONAL PEDIATRIC PULMONARY CENTERS

SEC. 42. (a) Section 511 of the Social Security Act is amended—

(1) by inserting "(a)" immediately after "SEC. 511.", and

(2) by adding at the end of the section:

"(b) (1) From the sums available under paragraph (2), the Secretary is authorized to make grants to public or nonprofit private regional pediatric respiratory centers, which are a part of (or are affiliated with) an institution of higher learning, to assist them in carrying out a program for the training and instruction (through demonstrations and otherwise) of health care personnel in the prevention, diagnosis and treatment of respiratory diseases in children and young adults, and in providing (through such program) needed health care services to children and young adults suffering from such diseases.

"(2) For the purpose of making grants under this subsection, there is authorized to be appropriated, for the fiscal year ending September 30, 1978, and each of the next four succeeding fiscal years, such sums (not in excess of $5,000,000 for any fiscal year) as may be necessary. Sums authorized to be appropriated for any fiscal year under this subsection for making grants for the purposes referred to in paragraph (1) shall be in addition to any sums authorized to be appropriated for such fiscal year for similar purposes under other provisions of this title.".

(b) Section 502 (2) of such Act is amended by inserting "(a)" immediately after "511".

WAIVER OF HUMAN EXPERIMENTATION PROVISION FOR MEDICARE AND MEDICAID

SEC. 43. Any requirements of title II of Public Law 93–348 otherwise held applicable are hereby waived with respect to programs established under titles XVIII and XIX of the Social Security Act.

DISCLOSURE OF AGGREGATE PAYMENTS TO PHYSCIANS

SEC. 44. Section 1106 of the Social Security Act is amended by adding:

"(f) The Secretary shall not make available, nor shall the State title XIX agency be required to make available to the public information relating to the amounts that have been paid to individual doctors of medicine or osteopathy by or on behalf of beneficiaries of the health programs established by titles XVIII or XIX, as the case may be, except as may be necessary to carry out the purposes of those titles or as may be specifically required by the provisions of other Federal law.".

RESOURCES OF MEDICAID APPLICANT TO INCLUDE CERTAIN PROPERTY PREVIOUSLY DISPOSED OF TO APPLICANT'S RELATIVE FOR LESS THAN MARKET VALUE

SEC. 45. Section 1904 of the Social Security Act is amended by adding the following sentence: "The Secretary shall not find that a State has failed to comply with the requirements of this title solely because it denies medical as-

sistance to an individual who would be ineligible for such assistance if, in determining whether he is eligible for benefits under title XVI of this Act, there were included in his resources any property owned by him within the preceding twelve months to the extent that he gave or sold that property to a relative for less than its fair market value.".

RATE OF RETURN ON NET EQUITY FOR FOR-PROFIT HOSPITALS

SEC. 46. (a) Section 1861 (v) (1) (B) of the Social Security Act is amended—

(1) in the first sentence thereof, by inserting "hospital or" immediately after "Such regulations in the case of",

(2) in the second sentence thereof, by striking out "one and one-half times" and inserting in lieu thereof "the percentages, specified in the next sentence, of" and

(3) by inserting after the last sentence of subparagraph (13) the following sentence: "For hospital and skilled nursing facility fiscal periods beginning before the month following the month of enactment of the Medicare-Medicaid Administrative and Reimbursement Reform Act, the percentage referred to in the previous sentence is 150 per cent and for subsequent fiscal years, the percentage is 200 per cent: *Provided, however,*

That no payments will be made under this subparagraph, in the case of a hospital, for October 1980 or any month thereafter.".

95TH CONGRESS
1ST SESSION

H. R. 7079

A BILL

To provide for the reform of the administrative and reimbursement procedures currently employed under the medicare and medicaid programs, and for other purposes.

By Mr. ROGERS

MAY 10, 1977

Referred jointly to the Committees on Ways and Means and Interstate and Foreign Commerce